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SUBJ/PUBLIC AFFAIRS-NAVAL SERVICE MEDICAL NEWS (NSMN) (94-47)//
POC/P.C. BISHOP/CAPT/MED-00P (PUBLIC AFFAIRS)/-/TEL:(202) 653-1315/TEL:DSN 294-1315/-//

RMKS/1. THIS SERVICE IS FOR GENERAL DISTRIBUTION OF INFORMATION AND NEWS OF INTEREST TO NAVY AND MARINE CORPS MEMBERS, CIVILIAN EMPLOYEES, FAMILY MEMBERS AND RETIRED BENEFICIARIES OF NAVY MEDICINE. MAXIMUM AND TIMELY REDISTRIBUTION OR FURTHER REPRODUCTION AND USE BY ACTION ADDRESSEES IS ENCOURAGED. THIS MESSAGE HAS BEEN COORDINATED WITH THE COMMANDANT OF THE MARINE CORPS (CMC). THE COMMANDANT HAS AUTHORIZED TRANSMISSION TO MARINE CORPS ACTIVITIES.

2. HEADLINES AND GENERAL INTEREST STORIES THIS WEEK:

HEADLINE: Corpsman Fights to Wear Combat Aircrew Insignia

NAMI Pensacola, FL (NSMN) -- Life isn't always fair, and stories don't always have happy endings.

But read on. This one does.

Our main character is one Hospital Corpsman Second Class Brian S. Hashey, from Hull, MA.

In November 1990, then third class Hashey's squadron, Marine Medium Helicopter Squadron Two Sixty-Five (HMM-265) reported to the Persian Gulf area for duty in support of Operations Desert Shield and Storm. Hashey had just qualified as a search and rescue (SAR) medical technician. During his one-year tour, he flew on several combat search and rescue/medevac missions and met all of the requirements and qualifications for designation as a combat aircrewman.

In March 1991, he was authorized to "permanently" wear the combat aircrew insignia on his uniform by the commanding officer of HMM-265. Appropriate entries were even made in his service record and NATOPS jacket.

He wore the Marine Corps Combat Aircrew Insignia proudly while routinely putting his life on the line in the not-so-friendly skies of the Middle East. No questions were asked.

But that ended when he reported to the Naval Aerospace and Operational Medical Institute (NAMI) in December 1991.

"When I got here my master chief told me the wings weren't

authorized on a Navy uniform."

Hashey was understandably upset.

"When you have 14 Marines put (the wings) into your chest, you don't like to lose something like that," said Hashey.

He asked the master chief what he had to do to get authorization to wear the insignia.

The master chief advised him to write a letter requesting authorization through the appropriate chain of command.

Enlisting (no pun intended) the advice and guidance of several knowledgeable chiefs, Hashey wrote a letter in December 1992, stating in part " ... I tend to believe that if a Department of the Navy force (U.S. Marine Corps) awards a designation (combat aircrew) to Department of the Navy personnel (i.e., myself) that a bilateral agreement of its wear should be in effect, somewhat like the Navy Achievement Medal or Naval Aircrew Wings awarded Marines."

Hashey sent the letter to the Secretary of the Navy, via the commanding officer of NAMI; the Force Master Chief; Chief, Bureau of Medicine and Surgery; the Sergeant Major of the Marine Corps; the Commandant of the Marine Corps; the Master Chief Petty Officer of the Navy; and the Chief of Naval Operations.

"By spring of this year, I'd only gotten one endorsement on it and hadn't heard anything else on it," Hashey said.

"So when Admiral Boorda came to Pensacola several months ago for CNO's call, I explained my situation to him during a question and answer session."

According to Hashey, that's when things really got rolling.

Boorda directed the Chief of Naval Education and Training's Force Master Chief to find out where the authorization request package was.

"For a while he couldn't find it. Seems someone had misplaced it somewhere up in Washington, DC."

But it was found, and a 15 September 1994 memorandum from the Chief of Naval Operations says it all:

"The Navy aircrewmen community manager and the hospital corpsmen community manager have reviewed the qualifications for the Combat Aircrew Insignia and determined it to be comparable to Navy qualifications ... recommend approval of the Marine Corps Combat Aircrew Insignia for wear on the Navy uniform."

The recommendation was finally approved by the Secretary of the Navy, and Hashey learned from HMCM Gary Becker on 15 November that he could indeed legally wear the wings he'd earned nearly four years previously.

Hashey's perseverance changed Navy policy. And thanks to his efforts, and the chiefs who helped him, eight other corpsmen who received Combat Aircrew Insignias in Desert Storm can now include the insignia with their other accumulated ribbons and medals.

"I was glad to make a mark," said Hashey. "And I can't thank Admiral Boorda or Chief Charles Ray enough for their help."

As promised, this story has a happy ending. Hashey may now wear his Combat Aircrew Insignia on his Navy uniform. But that's not all.

Hashey was recently selected (and has since reported) for

duty with the Navy Flight Demonstration Squadron, the Blue Angels.

I guess that's the military equivalent to living "happily ever after."

There's a simple moral to the story, too. The chain works, but sometimes you gotta yank it.

Story by Mike Antoine, Reprinted from the Gosport, 2 DEC 94

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HEADLINE: First and Proud

NAVHOSP Millington, TN (NSMN) -- In response to the Chief of Naval Operations' recent policy directing all active duty personnel to engage in aerobic exercise three times a week, Naval Hospital Millington took a page from the Nike handbook and "Just 'Did' It."

The question on everyone's mind after the directive was, "But, how?" In a Navy running on "doing more with less," it was clear that this would not be easily accomplished while maintaining the current work load.

Naval Hospital Millington is no exception, as the 36-bed hospital serves the entire South East Region, including 26 tenant commands at Naval Air Station Memphis, encompassing a beneficiary population of over 40,000 active duty, retirees and their family members. So, with the integrity of such a vital mission at stake, how do you get everyone on a three-times-a-week aerobic exercise schedule?

The man with the answer to that question is CAPT Michael Blome, the hospital's commanding officer. He immediately established a Process Action Team to explore all feasible avenues to arrive at the projected destination: full compliance with the directive without decreasing availability or quality of care, and doing it during normal working hours. After extensive research and direct involvement by Blome, Millington became the first naval hospital to successfully implement the program, and they did it with style. According to HMCM(SS) Michael Stewart, the Navy Medical Department's Force Master Chief, he knew of no other naval hospital with such an aggressive physical fitness program.

"We're excited to be able to get 730 people, which includes both active duty and civilians -- that's 1,460 happy feet -- involved in something that will benefit their personal quality of life and the Navy's mission," said Blome. "We're proud of the fact that the implementation was accomplished without decreasing the quality or accessibility of care."

HMCM(SW) Robert Frank, the hospital's Command Master Chief, is excited and proud too. As the personal leader of the command's remedial physical fitness program, this is just one more way for him to assure that his Sailors are getting prepared for the challenges that lie ahead. "You have to lead by example," said Frank. "You can't imagine the pride in seeing almost 400 staff personnel, led by the commanding officer, running in formation. Awesome."

In all honesty, the initial response from the command's personnel was, "We're gonna have to do what?" Let's not forget that we're dealing with people who are used to caring for others

from the start of their day until the finish. Couple that with the level of community involvement by the hospital staff and that leaves very little time for a personal life.

"The time management principles evoked by the program allow everyone the opportunity to exercise and still retain their pride in 'complete customer service.' In other words, we aren't making the patient suffer in order to enhance ourselves," said HMC Jay McCarty, Physical Readiness Training Coordinator for the Branch Medical Clinic, Naval Hospital Millington. The clinic is right on target with the program too, even though their day begins at 0545.

But Millington's program doesn't rest on just aerobic exercise. The Health Promotion Office offers classes and literature to augment fitness, including nutrition, exercise and general fitness information. "We're supplying them with knowledge as well as an exercise opportunity," said Health Promotion Officer, LCDR Steven Winter. "We're investing in our future. The result of this program will be better physical readiness test scores, fewer injuries, and a general better feeling about one's self."

If it seems that lots of people are involved in making this program work, you're right. Every staff person at Naval Hospital Millington, from the most junior enlisted to the commanding officer himself, including those with partial medical waivers, are responsible for the success of the program through 100 percent participation.

One aspect of the program is once a week mass physical fitness training. At that time, all personnel except those on duty muster in front of the hospital with the Command Master Chief for a session of supervised warm-up, calisthenics, stretches, sit-ups, push-ups, and a 1.5 mile formation run. This provides a great chance for camaraderie and esprit de corps for the entire staff.

"To get this program on line itself was a major achievement, but to have so many people excited and looking forward to physical fitness training is an accomplishment of colossal proportion," said CAPT Richard Buck, executive officer at the hospital.

It was indeed a tasking of great size, but in the true spirit of the Navy, Naval Hospital Millington "just did it" with pride and a lot of style.

Story by HM2 Darren Cawthon

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HEADLINE: GRAND ROUND ABSTRACTS

BUMED Washington (NSMN) -- RADM Joan M. Engel, NC, Director of the Navy Nurse Corps and Assistant Chief for Personnel Management, Bureau of Medicine and Surgery, was awarded Honorary Fellowship in the American Academy of Medical Administrators (AAMA) "for distinguished service in the field of Healthcare Administration." She was presented the award at the AAMA annual meeting, held 17 November in Orlando, FL.

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THE CAPITOL, Washington (NSMN) -- RADM John F. Eisold, MC,

who was frocked to his current rank 1 November, will be promoted 1 January 1995. Eisold will assume the prestigious position of Attending Physician to Congress upon the retirement of RADM Robert C. Krasner, MC, in January 1995.

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NMC Oakland, CA (NSMN) -- CAPT Ronald J. Clayton, MC, the Program Director of the Internal Medicine residency training program at Naval Medical Center Oakland was selected to receive the 1994 Henry J. Kaiser Award for Excellence in Teaching, given by the University of California in San Francisco.

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HEADLINE: High-Intensity Exercise Can Help Prevent Osteoporosis

AMA Chicago (NSMN) -- Older women may be able to avoid bone fractures due to osteoporosis by doing 45 minutes of high-intensity strength training exercises twice a week, according to an article in this week's Journal of the American Medical Association.

Miriam E. Nelson, PhD, from the Jean Mayer USDA Human Nutrition Research Center on Aging at Tufts University, Boston, and colleagues studied 39 white women, ages 50-70, who were sedentary and had been postmenopausal for at least five years. The women were asked not to alter their diet during the one-year study period and had not taken estrogen or any other medications known to affect bone during the previous 12 months.

Twenty women in the group were randomly chosen to participate in the high-intensity strength training program. They met twice a week with a trainer. They spent five minutes on an exercise cycle, five minutes using a stretching device and 45 minutes doing hip extensions, knee extensions, lateral pull-downs, back extensions, and abdominal flexing using a pneumatic resistance machine.

The remaining 19 women were in the control group. They were asked to maintain their present level of physical activity during the year.

The researchers found that the women in the high-intensity strength training program had increased bone mass and muscle mass, improved strength and balance, and were more motivated to participate in spontaneous physical activity. The women who did not exercise lost bone mass and muscle mass, had less strength and balance than their counterparts in the study, and were less eager to participate in physical activity.

The researchers say "low muscle mass, muscle strength, and poor balance are all risk factors for falls in the elderly and as has been demonstrated in this trial, have the potential to be modified by a single intervention."

In contrast, the study says traditional pharmacologic and nutritional approaches to the treatment or prevention of osteoporosis have the capacity to maintain or slow the loss of bone, but not the ability to improve balance, strength, muscle mass or physical activity level.

The researchers say "two days per week, 45 minutes per session, is a feasible amount of time to ask an older person to exercise, and therefore has the potential to be generalized to

the population at large, even to frail elders. Our previous work has indicated that nursing home residents with multiple chronic diseases are capable of performing strength-training exercises and experience improvements in strength, functional status, and mobility."

The researchers say the next step is to determine whether these exercises in a home-based or similar type setting can improve bone density over the long term, thus further reducing the risk of fracture due to injurious falls which could have a tremendous economic, societal and personal cost.

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SUBHEAD: NIH Consensus Conference on Calcium Intake

In a related article in this week's JAMA, the National Institutes of Health published the recommendations of a Consensus Development Conference on Optimal Calcium Intake, which found that a large percentage of Americans are not getting enough calcium.

The conference says the preferred source of calcium is through calcium-rich foods such as dairy products, but calcium-fortified foods and calcium supplements are good alternatives when food intake does not provide enough calcium.

The conference also says adequate vitamin D is essential for optimal calcium absorption. Vitamin D metabolites enhance calcium absorption.

High levels of calcium intake have several potential adverse side effects, including calcium toxicity, severe renal damage and ectopic calcium deposition; however, the conference report says calcium intake of up to 2000 mg per day appears to be safe in most individuals.

The Conference recommended an optimal daily intake of 1000 mg of calcium for women age 25-50, postmenopausal women on estrogens up to 65 years of age, and men over 24 but not yet 65; 1500 mg per day was recommended for both men and women over 65 years old and also for postmenopausal women not on estrogens. A daily intake of 1200-1500 mg was recommended for women who are pregnant or nursing, as well as people who are 11-24 years old. Other recommended daily intakes were: 800-1200 mg for children 6-10; 800-1200 mg for 1-5 year olds; 600 mg for infants six months to a year; and 400 mg daily from birth to six months.

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HEADLINE: HEALTHWATCH: Improving Health After Menopause

BMC Atsugi, Japan (NSMN) -- Since my wife and I have been in Japan, we have noticed something about the elderly women here that is not seen as often in the United States anymore: a bent over posture. This is what some would call a "dowager's hump" and is due to osteoporosis, the loss of calcium from bones that sets in after menopause. I have not spoken with any Japanese doctors about why this is so prevalent here in Japan, but it does bring up the topic of women after menopause. It also brings up the question of what, if anything, can be done for them?

In the United States, the American College of Obstetricians and Gynecologists (ACOG) has been recommending hormone

replacement therapy for almost all postmenopausal women for several years now. Hormone replacement therapy, or HRT, is where women take estrogen and progesterone pills to protect themselves from the detrimental effects of menopause. Despite this recommendation, though, many women are very hesitant to follow ACOG's advice.

I have heard some women explain that their hot flushes of menopause are not bad enough to warrant treatment. Others are reluctant because they believe that HRT is unnatural. Some are afraid of getting breast or uterine cancer from the pills, and still others feel that their period was a nuisance (or "curse") all of their adult lives. This latter group of women were glad when their menses stopped and, having heard that HRT would start the bleeding again, refuse this treatment despite all its claimed benefits.

On top of it all, hormone replacement is a daily task and a lifelong commitment. Not only does it involve taking pills every day, but it requires regular visits to the doctor. These are constant reminders that a woman is no longer as young and immortal as she once thought. So why in the world would any woman subject herself to HRT? And, why would ACOG -- an organization made up mostly of men, by the way -- push these pills on all the postmenopausal women of the world?

To answer these questions, we need to look at what happens to the female body during and after menopause.

Menopause is a group of symptoms that occur while a woman's body is becoming used to the lower levels of estrogen and progesterone that occur when her ovaries stop functioning. This process can take anywhere from a few months to over 10 years, and includes several uncomfortable symptoms. "Hot flushes," the technical term for the lay term "hot flashes," is the most well known of these. For those who have never experienced hot flushes, this symptom may seem trivial. However, their severity can vary greatly and, in their extreme, can be very disturbing. Other symptoms include drying and thinning of the genital tissue, which interferes with intercourse, and pelvic relaxation, which can cause several problems including urinary incontinence.

Women may also experience psychological symptoms. As with hot flushes, these may seem trivial to one who has never experienced menopause, but, again, their severity varies greatly. Psychological symptoms include insomnia, irritability, depression, confusion and memory loss. Many women have actually attempted suicide because of the depression caused by this "change of life."

Once the body is used to a low level of female hormones, the hot flushes and psychological symptoms may resolve. The changes to the genitalia and urinary incontinence continue, though, and may even worsen. Also, calcium is lost from bones, making them brittle. This is called osteoporosis. The dowager's hump I mentioned earlier results from numerous fractures that occur in the neck and back, all the result of osteoporosis. Fractures of the hips, wrists and ribs also become more common. All of these are painful, and some may even be fatal. These fractures also occur with a level of trauma that would seem insignificant in a

younger woman.

After menopause, women also become more susceptible to vascular diseases, which include heart attacks and strokes. Estrogen protects younger women from these diseases, perhaps by lowering the serum cholesterol levels, but after menopause women loose this protection.

The goal of hormone replacement therapy is to do just what its name implies: to replace the hormones that were lost when the ovaries stopped functioning at the beginning of menopause. Although their effects vary somewhat among women, the estrogen and progesterone pills used in HRT usually improve all of the symptoms of menopause. They also prevent osteoporosis and reduce the risk of cardiovascular diseases. Of these benefits, the cardiovascular effects are probably the greatest reason why ACOG has recommended HRT for most postmenopausal women. Studies have shown that the risk of heart attacks and strokes drops by about 50 percent for women on hormone replacement.

The downside of HRT is small. There are some misconceptions floating around, though, that make this therapy less desirable than it should be. Some have felt in the past that HRT increases the risk of breast and uterus cancer. However, studies over the past 10 years have shown that not only does the risk of these cancers not increase with hormone replacement, it may actually decrease -- even in women with a strong family history of breast cancer.

Another worry of HRT is that it may bring back menstrual bleeding. With the current daily regimen, though, most bleeding stops within three to six months. Other fears include an increased risk of blood clots forming in the body and an increased incidence of gallbladder disease. These two latter conditions, however, could not be consistently confirmed in repeated studies. Still, if there is strong reason to suspect that a woman may be at risk for forming excessive blood clots, she probably should not take hormone replacement.

Unfortunately, there is no way around the fact that HRT is a life-long treatment. The pills cost money, and so do visits to the doctor. These costs are out-weighed, however, by the probable improvement in a woman's quality of life as well as savings from the decreases in osteoporosis, cardiovascular diseases and the various other conditions that result from menopause.

Hormone replacement therapy offers women the option of aging with health, or at least better health. Since the vast majority of postmenopausal women can benefit from it, I would suggest that any such woman who is not already on HRT make an appointment with her doctor to discuss what benefits hormone replacement therapy may offer her.

Story by LT Daniel Goddard, MC, a family practitioner at Branch Medical Clinic Atsugi

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3. Professional Notes: Information on upcoming symposiums, conferences or courses of interest to Navy Medical Department personnel and wrap-ups on ones attended. Anyone with information

to share in this section should contact the editor (see the last paragraph of this message on ways to do so).

Scheduled Meetings:

-- 4 February 1995, 2nd Annual Update in Behavioral/ Developmental Pediatrics, University of California San Francisco; (415) 476-4251.

-- 1-4 March 1995, 20th National Conference of the American Academy of Ambulatory Care Nursing, "Enhance Healthcare Systems through Strategic Alliances," Washington, DC. Call AAACN at (609) 256-2350 for a brochure.

-- 4-10 March 1995, 36th Navy Occupational Health and Preventive Medicine Workshop, "Prevention and Protection: Our Global Commitment," Hampton, VA. For more information, call NEHC's Workshop Hotline at (804) 444-7575, x432 (DSN prefix, 564-).

-- 20-22 March 1995, Fourth Annual Advanced Training Seminar in Hyperbaric Medicine, sponsored by Richland Memorial Hospital and the University of South Carolina School of Medicine. For registration information, write to Hyperbaric Medicine, Five Richland Medical Park, Columbia, SC 29203; (803) 434-7101.

-- 20-24 March 1995, Shea-Arentzen Nursing Symposium 1995, "Navigating New Frontiers of Nursing Practice: The Challenges of Health Care Reform," La Jolla, CA. Contact CDR Chris Laurent, NC, or CDR Bill Aiken, NC, at DSN 522-6412 or (619) 532-6412 for more information.

-- 11-13 April 1995, Navy League's Sea-Air-Space Symposium, "Sea Power for the 21st Century," Sheraton Washington Hotel, DC. For more information, contact the Navy League of the United States at (703) 528-1775.

-- 20-22 April 1995, Postgraduate Course in General Surgery, University of California, San Francisco. For registration information call (415) 476-5808; for program information call (415) 476-4251.

-- 25-27 May 1994, 11th Annual Current Issues in Anatomic Pathology, University of California School of Medicine, (415) 476-4251.

-- 5-8 June 1995, HHS International Congress on Hazardous Waste: Impact on Human and Ecological Health, Atlanta. Deadline for abstracts is 1 February 1995. For information, contact Dr. John S. Andrews, Jr., Associate Administrator for Science, Agency for Toxic Substances and Disease Registry, 1600 Clifton Rd., NE (E-28), Atlanta, GA 30333; (404) 639-0708, e-mail JSAI@ATSOAA1.EM.CDC.GOV.

-- 19-22 June 1995, Third Annual NAVSEA/NAVSUP International Logistics Symposium, "Logistics Teaming for International Defense," Hyatt Regency Hotel, Arlington, VA. For program information contact Sandra Kramer, NAVSEA, (703) 602-9000; contact Sally Cook, ASNE, (703) 836-6727, for registration information; and to reserve exhibit space, contact John Werbowski, (703) 329-4201.

-- 9-11 November 1995, The Integrated Function of the Lumbar Spine and Sacroiliac Joints, San Diego. Deadline for abstracts is 13 January 1995. Direct inquiries and submissions to European Conference Organizers, P.O. Box 4334, 3006 AH Rotterdam, The

Netherlands; 31-10-4133287.

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4. Events and observances occurring 8-16 January:

8-14 January: National Patient Representation and Consumer Affairs Week -- Theme: "Up With Patients" (312/422-3999)

9 January 1945: U.S. Sixth Army lands on main Philippine island of Luzon

10 January: Morning (0600-0800) and Night (until 2200) Detailing (times are for Washington DC)

10 January: Active E-8/9 Special board convenes

10 January 1920: League of Nations created

11 January 1964: U.S. Surgeon General Luther Terry issued first government report that smoking may be hazardous to health

12 January 1945: Soviets launch massive offensive against Germans in Poland

15 January 1929: Martin Luther King Jr. born

16 January: Holiday -- Martin Luther King Jr. Day

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5. ADDRESSEES ARE ENCOURAGED TO SUBMIT INFORMATION AND NEWS ITEMS OF MEDICAL DEPARTMENT OR BENEFICIARY INTEREST (IN STORY FORMAT) BY TELEPHONE, FAX OR E-MAIL TO BUMED, ATTN: EDITOR, NAVAL SERVICE MEDICAL NEWS (MED 00P2). TELEPHONE (202) 653-0793, DSN 294-0793. FAX (202) 653-0086, DSN 294-0086. E-MAIL NMC0ENL@BUMED10.MED.NAVY.MIL//

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